

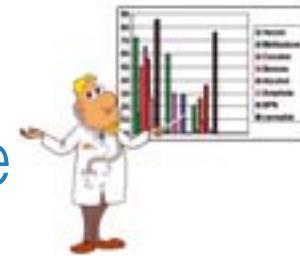


Poly drug use: taking it on in UK general practice

Poly drug use is the norm and the Lonsdale Medical Centre team of Chris Ford, James Oliver, Brian Whitehead and Janet Gillespie describe successfully working with the person rather than the drug in general practice. **Ed.**

Key messages

- 1) Poly-drug use is now the norm in the UK – treating opioid dependence alone is no longer possible
- 2) Poly-drug use can be successfully managed in General Practice
- 3) Drug treatment needs to be about the person rather than drug



Introduction

Patterns of drug use in the United Kingdom have been subject to variation in recent decades. Heroin use has been steadily increasing and other sedatives have become more prominent particularly benzodiazepines. The use of stimulants such as amphetamines, cocaine (powder and crack) is becoming increasingly commonplace. Biphasic drugs such as alcohol, cannabis and nicotine have been, and remain the most commonly used addictive substances.

...continued overleaf

In this issue

Poly drug use is the norm. A must read – see above. **pages 1-2.**

Non-medical prescribing – one year on. Improving what's been done for years and giving us a more accessible and flexible prescribing or indeed taking us back to a narrow more prescriptive form of treatment? Still finding its way, Simon Greasley updates the discussion. **Page 3.**

Nat Wright describes **Setting up a Drug Service in Prison** as 'the best of times and the worst of times', find out why on **page 4.**

Readers views following our last edition GPwSI article – what is the future, will some GPs us be redefined out of existence? Also, a personal tribute to Dr Michael Varnam. **Page 6.**

The virtue of ignorance - Phil Barker challenges us to drop the 'specialism' and remember it is the person that we work with. Consider ignorance as a starting point ... A fundamental and philosophical delight! **Page 7.**

Stephan Ibanez-de-Benito conducts a thorough examination of **clinical governance as the management of patient centred organisational change.** **Pages 8-9.**

Kate Halliday reports on the **Effective Coordination of Shared Care** day exploring support forums, role development and shared practice, held on 26th April in Manchester, **page 10.** Also on **page 10**, Nat Wright highlights the Joseph Rowntree report on the piloting of **drug consumption rooms** as a pragmatic response to public injecting.

Keep updated with substance misuse texts and sources online.... Email updates, feeds, blogs, alerts, listings... approving nods or maybe no idea what this means? Worth a read either way as Anne Welsh from DrugScope makes the great web library a lot easier to access. **Page 11.**

Heresy dogma and inquisition...supervised consumption. Counter-productive invasion of human rights or effective aid to treatment? In the first of two articles Nigel Modern distinguishes the articles of faith that make it heresy for some and orthodoxy for others. **Page 12.**

Charlie Lowe as **Dr Fixit on using clinical governance to bring about change with GPs who are under-dosing...akin to herding cats!** **Page 13.** Ewan Stewart, continues his **Dr Fixit from last issue with a patient who returns with a HIV+ test result,** **page 14.** Kim Wolff addresses **Sleep management and methadone**, a topic that many seem unsure about, **page 15**, also **Models of Care for Alcohol Misusers** by Linda Harris.

Updates and announcements on **page 16.**

Enjoy the read

Jean-Claude Barjolin

Editor

Conference news ...and... it's Birmingham! Next year's 12th National Conference on Managing Drug Users in Primary Care is to be at the Hilton Birmingham Metropole Hotel from 18th – 20th April. This year's Manchester feedback indicated a resounding success with 91% of delegates finding it good or excellent. Listening to other feedback indicating room for improvement, planning is underway for next year. So watch this space ...

2006 conference consensus statement

RCGP 11th National Conference: Management of Drug Users in Primary Care. Are we Delivering Effective Care in General Practice? Manchester International Convention Centre 27th-28th April 2006

This conference believes that:

- Effective care for drug users is being delivered in general practice, because we have inherent ability and flexibility to see the person rather than the drug
- Good care is dependent upon all players, including service users and carers, working well together in a whole system approach which is adequately resourced
- However, provision remains patchy
- We all need to:
 - Take up the challenge to audit and evaluate our work
 - Train and offer training opportunities to undergraduates and graduates
 - Actively promote good practice amongst other colleagues in general practice and the wider drugs field
 - With colleagues, develop a nationally agreed outcome monitoring tool
- We call upon the NTA, HCC, Government and local commissioners to take account of the effectiveness of primary care provision and ensure universal coverage of this within an overall systems approach



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Requests to mark@smmgp2.demon.co.uk

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Of particular importance in these changing patterns of drug use is the emergence of poly-drug use, which we define as the concurrent use of more than one drug including alcohol. This development has been fuelled by increased availability, relative reduction in price, emergence of new drugs and the introduction of more potent formulations of traditional drugs such as crack cocaine.

Drug combinations:

- Drugs are often taken in combination to increase their effects, heighten the experience of the primary drug or sometimes to reduce negative effects
- There is some possibility that people using one drug can predict its effect, but this becomes more difficult when they are taken in combination
- The risks of poly-drug use become harder to define
- When two or more substances are taken in sub-lethal amounts, the combination may be capable of causing death ⁽¹⁾
- People may also be in different stages of their using with each drug and at different stages of change for each drug
- Alcohol is a very large problem in drug users presenting to treatment, and is not often successfully addressed ⁽²⁾
- Cannabis is used regularly by 70-85% of Class A drug users
- Most do not see cannabis use as a problem and are not looking for treatment for it ⁽³⁾
- Risk behaviour and psychiatric co-morbidity is higher in poly-drug users

Common combinations in use in our area:

1. Cocaine / crack and heroin injected together to increase effect of both
2. Cocaine and benzodiazepines and /or alcohol and / or cannabis
3. Heroin and / or methadone and / or benzodiazepines and / or alcohol and / or cannabis
4. Amphetamines and heroin/methadone and benzodiazepines and / or alcohol and / or cannabis

Poly-drug use treatment

Treating the drug rather than the person is no longer (if it ever was) possible or acceptable. For too long many drug services and shared care schemes have focused on the drug, often opioids and substitute prescribing and forgotten the person, who as well as other drug problems may have a number of other problems such as: housing, financial, other drugs, alcohol and this needs to change.

Using combinations of drugs is the norm in those seeking treatment and those in treatment. People using one drug can predict its effect, but this becomes more difficult when they are

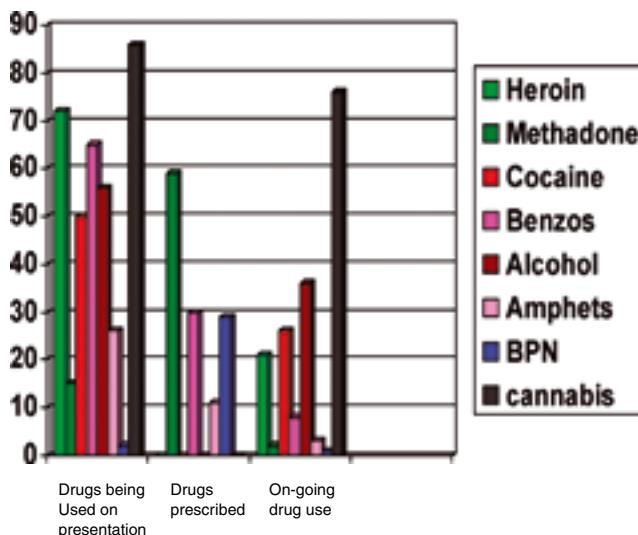
taken in combinations. The risks become much harder to define and users may be unaware of the risks. They also may be in different stages of their using with each drug and at different stages of change for each drug.

Can we successfully manage poly drug use in a general practice? Yes!

- In general practice we treat the person rather than the drug
- Poly-drug use should be no different than managing anyone else with multiple problems and multiple medications
- Retention rates are very high (98% in one year)
- Keep people in treatment whatever they are using and wherever they are on their treatment journey

We ensure treatment is as flexible as possible and includes substitute prescribing and non-prescribing options and involve users in their own treatment package

Use of substances at presentation, what is prescribed and on-going drug use



How we successfully manage poly-drug use in one general practice

1. People who present for help are always at the centre of their care
 - They decide on their priorities and their care-plan
2. Accessibility:
 - Not excluding poly-drug users – no-one living in the practice area is excluded, whatever they are using
 - Assessment are undertaken by counsellor or doctor and focus on the person rather than the 'primary' drug
 - No waiting list
3. Health care:
 - Full general medical services provided
4. Include substitute prescribing and non-prescribing options:
 - Full range of prescribing: opioid substitutes, amphetamines, benzodiazepines

- Listening therapies particularly client centred therapy, motivational interviewing and cognitive behavioural therapy
- Provide not just a prescription but also a whole range of treatments with flexibility and understanding

5. All staff trained to deal with person not drug

- In house joint training of reception staff, doctors, counsellors, nurses et al

6. Always use multidisciplinary working

- Involve the practice team
- Plus outside agencies such as housing, Social Services, health visitors etc, where appropriate

Conclusion

Poly-drug use can be managed successfully in general practice and the key to this is working with the person and not purely focusing on one drug. The relationship with the patient is a positive part of treatment, and by working with them, whatever they are using and where ever they are in their drug career or treatment journey we can show marked improvements in their health and well-being and empower them to decide on the right treatment for themselves.

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Non-medical prescribing – one year on

Improving what's been done for years and giving us a more accessible and flexible prescribing or indeed taking us back to a narrow more prescriptive form of treatment? Still finding its way, Simon Greasley updates the discussion. Ed.

History

I could not write this article without first going back into the online forums on the SMMGP website to see how we have got to where we are now. Over the last year or so, there have been rapid changes and it has been difficult for everyone to keep up.

There seemed to be a lot of confusion when the amendments to the Misuse of Drugs Act (2001) came into force in April 2005. These amendments allowed nurses to be supplementary prescribers for substance misuse patients. *It seemed that nobody knew which prescriptions we could use and, in fact, initially nurses were denied the use of instalment prescriptions, which would make it extremely difficult to prescribe controlled drugs in this specialism.* Initially we were denied hand writing exemptions, I'm sure it was not that people intended to be difficult, it seemed more that it hadn't been considered that nurses would prescribe in this area. Things rapidly moved and pharmacists were also allowed to become supplementary prescribers.

It was strange to work with a two-tier system between what we could prescribe independently and what we could prescribe supplementary. Independently there were set conditions with set medications to treat that condition. This proved rather inflexible, for example it was possible to prescribe analgesia for back / neck pain but not for tooth ache. These restrictions have since been removed and since May 2006 legislation has permitted independent prescribing for nurses and pharmacists from a full formulary, excluding most controlled drugs.

Nurses / key-workers have no doubt suggested dose changes to methadone / buprenorphine regimes for many years and the supplementary prescribing validates this relationship. It is quite clear that the doctor (independent prescriber) has to make the initial diagnosis and agree a clinical management plan before the supplementary prescriber can initiate a prescription. Previously this relationship may not have been so strictly enforced. In law this means in our practice we have a joint consultation and formulate treatment plans together.

Clinical management plans

The clinical management plan (CMP) as already mentioned has to be agreed before the supplementary prescriber 'initiates' treatment that requires a CMP.

CMP's need to include the patient's name, reason for treatment, allergies, medication that is included in the plan and a dose range, adverse drug reaction reporting, research or protocol supporting the plan and review dates. The CMP is agreed with the independent and supplementary prescriber and the patient.

I initially set my plans to be quite restrictive with lots of reasons to refer back to the doctor, which just meant I would need to refer back to the doctor a lot. I guess this was to do with a fear of getting things wrong and a worry that prescribing in this area may be a bit more high profile. The CMP's we have now are to the same dose ranges as the RCGP guidelines. The CMP's work as a template on the computer system which saves as a Word document and can be printed for the patient.

In May 2005 with CMP's in place and prescriptions duly reauthorized in my name I took the plunge to do my first controlled drug prescriptions. A sleepless night helped raise my anxiety, checking the prescription several times, before asking each pharmacist to check them a few times also.

Fortunately the next day after careful checking there were no police cars waiting for me in the car park and I had this feeling of 'Wow I got away with it'. Not that there was anything illegal.....It just felt like it!

...continued on page 5



Setting up a drug service in prison

Nat Wright untangles the harm reduction verses security paradox yet challenges the myth that 'prisons are awash with drugs'. Opening a few prison doors proves to be 'the best of times and the worst of times'. Ed.

Three years ago I was approached by the prison health care department at HMP Leeds to provide input into the provision of treatment services to drug users. The context at that time was that a number of users had been successful in taking legal action against the prison for substandard care they had received whilst in the prison. In particular users coming in on maintenance methadone medication were put on detoxification programmes that only lasted a number of days and so putting them at risk of self-harm and suicide. Having worked in the prison now for three years it has become apparent that the Leeds situation was by no means unusual and national data supports that the user is at high risk in the first week of their sentence.

In October 2005 I moved to working full-time in HMP Leeds and found that in

words of Dickens 'It's the best of times and the worst of times'. The best of times? Confident that there was an evidence base for maintenance prescribing of opiates in the prison setting¹ we initiated over 2000 methadone prescriptions to users in the last year. Just last month I was informed by the local drug related death investigator that the number of deaths related to post prison release has dropped from an average of 6 per year to zero this year for Leeds alone. It is probable that other areas of West Yorkshire which are served by HMP Leeds will also have seen a drop in the drug related death rate post-prison release. The relationship with security staff is evolving as we gain a greater understanding of each others' agendas and working practices. Often a prison officer would approach me and ask why we were providing opiate maintenance in the prison. Either explicit or implicit in the question was the view that drug use was deviant behaviour and that the users should be given one chance to 'get off' drugs. We have worked hard on raising awareness that drug dependence is a clinical condition for which there is now an evidence base for opiate maintenance therapy. However, the relationship between harm reduction interventions and the need to maintain security in a prison setting still has the potential for controversy, and yes I suppose it does highlight that the 'best of times' are often accompanied by the 'worst of times'.

The worst of times is currently being played out as we seek to find the best way to provide buprenorphine medication to drug users. One of the myths of drugs in prisons is that there is more drugs in the prison than there is in the community. I still hear people say 'prisons are awash with drugs', or 'there's more drugs inside than outside'. However the first thing that hit me when I started working with drug users inside the prison was that the amount of drugs they reported to be using was much less than reports of use in the community. This raises questions as to what the correct dosing regime is for maintenance in the prison setting. Recently I read with interest a report by the European Network of Drug Services in Prison² which stated that clinicians who practiced in both the prison and community, tended to provide lower dosing regimes to users in the prison setting compared to when they prescribed in the community. It is interesting that many users in prison report feeling stable on doses of 30-50 ml per day. It is possible that injecting drug users stop the practice of injecting drugs whilst resident in the prison setting.³ However as prison doctors we do have a responsibility to review such users in the month prior to release as most (if not all) will require titration to adequate community dose levels (typically 60-120ml per day of methadone) prior to their release. Buprenorphine prescribing in the prison setting remains a difficult issue as a culture of removal from the sublingual area and sale is commonplace. Balancing security/clinical governance requirements with service user choice with respect to their medication remains a difficult balance to achieve. We have been trying to resolve this by working with security staff with respect to what to do if a user has removed their buprenorphine medication with intent to sell. Whilst some would recommend we stop the medication and withdraw all maintenance therapy we have decided that it is more appropriate to switch to methadone maintenance. In effect we are saying that the user may still need opiate maintenance but that buprenorphine maintenance whilst in the prison is not for them. Inevitably, working in an area where there is a high demand for drugs due to reduced supply our service has to be more regulated than it would be if we were practicing in the community.

Some might ask whether we have gone soft on detoxification? I would like to think not - one of the big positives of

working in the prison is that there are 'drug free wings' where it is possible for users to offer voluntary testing. On such wings it is much easier to become and remain abstinent if the user so chooses. Whilst some could say that care is being ghettoised we prefer to see it as the prison being a unique residential environment where users can be offered either maintenance or abstinence services according to individual need.

Finally, one of the first things that struck me when I started working in the prison was the use of the door in the primary care consultation. Whenever I worked as a GP in the community the patient would enter the room and close the door. It was an action that was undertaken subconsciously and I never gave it any thought. However it quickly became apparent that many users would enter the room without closing the door and would be quite surprised if I asked them to close it. One even went so far as to say 'Do you feel safe though doctor?'. Of course with all those security staff and panic alarms around I feel that it's the safest place in Leeds to consult. However, it made me wonder why the culture of leaving doors open to consult was so widespread. Was it for doctors to feel safe? Or could it be used by doctors to try and keep the length of the consultation short? Certainly I have felt that where users are quick to close the door there often follows a persistent request for medication (usually benzodiazepines). Whatever the reason I did feel uncomfortable with the practice as it felt that the user was to some extent disempowered in the consultation, so I now encourage all users to shut the door when they enter the room. It feels a fundamental health right that they are entitled to see a doctor in privacy where their confidentiality is assured.

In conclusion, it is not possible to provide a comprehensive overview of our service. However I hope it will encourage some to take the step of working (if only for part of their week) in the prison.

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- Keep CMP's simple.
- Do CMP's when the patient is present.
- Do not be too restrictive with the CMP's, it will mean constantly referring back to the independent prescriber.
- Make sure everyone understands the reason for CMP's.
- Make dates for CMP reviews realistic i.e. no point saying they will be reviewed every month if you go on holiday for a month.
- Know your limitations and work as a partnership.

It has to be appreciated that a treatment/care plan is a way for the prescribing team to work with the patient, so a clinical management plan is no different to this and could be seen as a replacement. The doctor and non-medical prescriber can be interchangeable in consultations, that is to say, it's possible to cover each other's clinics.

Practice implications

I imagine people want to hear that non-medical prescribing is safe and this is what we need to demonstrate. Non-medical prescribing is in its infancy within the area of substitute prescribing. In time there will be research to demonstrate safety and effectiveness. 'Prescribing' decisions have been made on behalf of doctors for many years and as mentioned previously, prescribing by non-medics validates this. Nurses have indeed become very experienced in chronic disease management. There are wider implication for prescribing and other people who have been involved in the prescribing process. It could well be seen that in future, other professionals may be able to prescribe; it could be the same professionals that have been involved in this process for years. For our practice it means that we have increased the number of patients in treatment, and I'm sure that is what we all want. Non-medical prescribing has its limitations and general practitioners are able to prescribe for the whole person. Luker et al (1998) found that patients felt that the nurse gave them more time to discuss their problems. *I think it is therefore important that this continues and the nurse or pharmacist does not become a GP 'On the cheap'.* It has also been reported by Harniman (2006) that non-medical prescribing creates a 'seamless service' and when questioned, clients all gave favourable replies to a nurse prescribing their medication.

Other considerations

It is important to mention clinical governance and sound record keeping and at least for nurses, the Nursing and Midwifery Council will expect further professional development. It may be beneficial to have some extra protected study leave. Expanding knowledge will enhance the prescribing ability; look for skills and knowledge gaps. Indemnity insurance needs maintaining and job descriptions will need alterations. It has to be remembered that nurses and pharmacists should not prescribe outside of their scope of practice.

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Reader's views · Reader's views · Reader's views

The GPwSI - Redefined out of existence?!

Readers give their views following our last Edition 14 article on GPs with Special Interest. Is there a future for the GPSI role? Ed

Article link

<http://www.smmgp.org.uk/html/newsletters/net014.php#GPwSI>

Dr Shahid Dadaboy: I trust that you are well. I must say that I enjoyed your article in the most recent Network newsletter. It raises a lot of very salient points regarding what the GPwSI role is for. I myself am probably in the GPwSI developmental domain and am thinking of migrating to the clinical role at present. The article raises a lot of soul searching. My view and concern is that with practice based commissioning this already Cinderella service will not be visited by the Fiscal Fairy Godmother by PBC groups. I acknowledge that there is a danger that GPwSI in substance

misuse in a clinical role at least will end up providing more and more specialised services, however in the new emerging microeconomic health landscape that is the reality across the board. In terms of rolling out Substance Misuse as a core Primary Care Service maybe defeatist but sadly probably the cynical reality.

Dr Susi Harris: Agree, much confusion/debate [exists] regarding this role. Primary care substance misuse has evolved organically in response to unmet need, and only now are we trying to draw lines around the workforce to define people into their roles. Speaking as someone who doesn't seem to fit neatly into any box, it's rather uncomfortable to think I may be redefined out of existence!There will be some of this confusion in all specialties, but none, I suspect so great as that in substance misuse.

Dr James Mather: I agree with Susi. Working in substance use and diabetes/cardiovascular risk management with postgraduate qualifications in both as well as being a GP in a thriving partnership, I see the definitions of who does what and with which group of patients blurring. I do see PBC as a way of primary care deciding those definitions and taking

them forward. Working both in primary and secondary care I see there is a role for the "experienced" GP to service at least 80% of the secondary care referrals. My main experience is in diabetes and cardiovascular risk management but I also have considerable experience in substance use work. The GPSI work could save the NHS a lot of money and provide a far better service than the "SHO roundabout" of secondary care outpatients. The difficulty is setting a service interface that uses the best skills of all providers. This is already being developed in diabetes management with community based teams notably in Bradford and Coventry. We can do the same in this field with some clear thinking and support. I am convinced PBC could do this with some clear thinking from service providers (along with the inevitable business case!). James.

Extracts from smmgp correspondence and the www.smmgp.org online discussion forum – check it out



Tribute to Michael Varnam

A wonderful and inspiring GP who strove passionately to tackle health inequality, service development and vocational training. Ed.



I am sad to report that Michael Varnam died peacefully at home on the evening of Saturday 29 April, having been unwell since January.

He was a wonderful, big hearted & larger than life character who, I imagine,

has achieved more for the drug using fraternity of Nottingham than any other individual...

Michael devoted his life to the cause of improving health and his commitment was quite extraordinary. In the early part of his career he was committed to the quality of general practice as a provider: from ensuring that GPs are properly trained, through his efforts in establishing the Vocational Training Scheme, to ensuring that GPs provide a high quality service, through his championing of audit. He was instrumental in establishing fundamental changes to the way GP services are provided locally, to this day.

15 years ago he deliberately moved to practise in a deprived inner-city area of Nottingham, establishing the Windmill Practice which remains a beacon in terms of providing services to local patients, including the homeless and those with substance misuse problems. His public health training and outlook led him to believe that the only way to

improve the health of the local population was through simultaneously tackling the determinants of health inequalities, and that it was his duty as a doctor to do so.

He promoted this approach through his national appointments, most recently as Vice Chair of the Health Development Agency, and also local work encouraging joint working between agencies responsible for housing, health, probation and crime.

He always said that he would never retire from this work. True to form, on the morning of his death he addressed a national Christian medical conference on the topic of serving others...and received a standing ovation. His dignity and composure right up until the end shows the strength of Michael's character and his ability to be an example to us all. He will be sorely missed.

Dr Stephen Willott

GP partner at the Windmill Practice & Drugs lead for the SDHIV Task Group



Phil – the person: 'We have our own story'

The virtue of ignorance

'So how you doing?' Phil Barker challenges us to drop the 'specialism' and remember it is the person we work with. Consider ignorance as a starting point! Ed.

A very short story: At 2 am Karen sat down to write to someone she had never met:

'I can't believe that this thing I despised is one of the things that helped me the most. I feel like my own voice is heard. I'm not just another patient. I am a person with goals and dreams and a life worth living. I want to thank you for giving me, and hopefully many others, that voice. Now I know that I can think, decide and act for myself. I don't need someone else to save me anymore, because you have given me the opportunity to save myself.'

First encounters

How do you open a conversation? 'Relate to me something of the nature of your lived-experience'. Well, maybe not. I'm more likely to say: 'So how you doing?' This slips off my tongue as easily as it does off Tony Soprano's. It means exactly what we say. Had I had met Karen in person this is where I would have begun. *Experience* – where else can you begin any relationship.

The professions have grown increasingly specialised and knowledgeable, but in practical terms they have become less smart. Perhaps we all have overdosed on the 'ologies': psychology, sociology, and anthropology, not to mention medicine, the human-science-ology. All interesting stuff, if you're on University Challenge, but they tell us nothing about individual people like Karen. She is her own world expert and so every meeting with her is a privileged audience; so I ask her, respectfully – 'how you doing?'

Karen had been clean for four years when she sent that email in the wee small hours. She still wrestles with demons, some which are part of her addiction to drugs and alcohol and others that are just another part of the experience of being Karen. But she had just discovered gratitude and wanted to share it with me.

She was grateful to the therapist who had patiently guided her into abstinence, but like many emotional discoveries her gratitude had been forged painfully. The burning factor had been the therapist's use of ignorance. At first, this threw her. She had been used to 'experts', keen to parade their knowledge; shaping and channelling her chaotic life. This profession of ignorance freaked her. She realised she wasn't just drug-dependent – she was an expert-guidance-junkie, dreaming of the technology that would issue the miracle cure. What she got was a friendly, respectful, compassionate and shamelessly ignorant person, who kept steering the conversation back to Karen. As if she knew what to do – she was the client!

In time the thing Karen despised (www.tidal-model.co.uk) became the thing that helped most, or so she thought. This is the logic of experience, which explained her attitude of gratitude at 2am. As designer of Tidal she felt that she owed me something. I felt duly humbled. On reflection, I realised that humility was ingrained in my therapeutic philosophy, if that doesn't sound too grandiose. Earning a living by trying to be useful to people has to be a privilege. If all the 'work' involves is listening to them, then this has to be a supreme privilege.

In following my philosophy Karen's Canadian therapist had begun in ignorance, and maintained this throughout the therapy. Consequently, Karen had to describe why she first *started* taking drugs, why she *continued*, what might be her reasons for *abstaining*, and what *problems* she anticipated. In short, she had to work at explaining herself. With each session she heard her own voice grow louder and stronger. At times she heard her voice say things that she had not heard before. Maybe that was the miracle.

OK, it's hardly 'rocket science'. Indeed, it is a whole lot more useful. The human sciences give us a false sense of security. We think we know what 'makes people tick', but all we know is the story of some theory. There, Karen and I share common ground: we have never been subjects in any of these 'grand narratives'. We have our own story. If anyone asks, we might well tell it like it is.

Why people take drugs seems straightforward. Drugs change our experience. Natural experience isn't quite enough, so we tinker with it. The effect may not last, but nothing lasts in the final analysis. That's the general story. There may be other social, cultural, incidental and accidental factors that influence the addiction story, but ultimately it is personal. A person takes the drugs, experiences the effects, and frequently the interpersonal, and social fall-out. So, we return to the person, to gain some sense of what exactly is going on and where this might go next.

Ignorance may not be bliss but it can be a life-saver – at least for people like Karen.

Phil Barker is a psychotherapist and Visiting professor at Trinity College Dublin

Clinical governance and change

Stephane Ibanez-de-Benito conducts a thorough examination of clinical governance as the management of patient centred organisational change. Ed.

'When people who are not used to speaking are heard by people who are not used to listening, then real change occurs.' Dame Rennie Fritchie

In 1948 the National Health Service was established with no particular agenda for quality. It was assumed appropriate quality would result from the provision of an infrastructure and the training and education of staff. "Quality was seen as inherent in the system, sustained by the ethos and skills of the health professionals working within it". Professionals and patients would no doubt define quality in different ways. Clinicians may justifiably focus on ``doing the right things, for the right people, at the right time, and doing them right first time" (Donald & Richardson, 1998)

Clinical governance can be viewed as a whole system cultural change which provides the means of developing the organisational capability to deliver sustainable, accountable, patient focused, quality assured healthcare. Clinical Governance was defined as: '... a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.' (Donaldson and Gray, 1998).

As a definition this is correct. However, what this means in shared care '...It's about everything we do to improve the quality of care that people received from us', '...It's everyone business' What is at the heart of clinical governance: The ability to improve practice and service by being able to make changes happen.

As we define quality in the context of clinical governance initiatives we must embrace professional and patient perspectives and priorities and we must determine each in a spirit of 'authentic curiosity'. The aims of the clinical governance in shared care are to raise patient satisfaction, improve collaborative relationships and efficiency within and across clinical teams, increase job satisfaction for professionals, improve clinical outcome and reduce significant events. These aims do not have any meaning for patients. Patients '...do not feel qualified to judge technical quality, they assess their health care by other dimensions which reflect what they personally value' (Kenagy et al., 1999). The core dimension described by patients are respecting their values, preferences and expressed needs; access to care; emotional support; information, communication and education; co-ordination of care; physical comfort; involvement of family and friends; continuity and transition.

Much has been said over recent years to build the agenda of empowering patients, and to create a partnership on an equal footing between patients and health and social care professionals. But staff need help to work through what can

often be a fundamental change for them too. When we look at why staff and patients are worried about involvement, we see that many of the fears are very similar (Table 1). Once that mutual understanding is reached, there is a realisation that actually we are all in the same boat. You could ask anyone the question: 'What if it was my wife, or daughter, husband or grandfather who came here for treatment?' As a son of a dependent alcoholic, I ask myself everyday the same question.

Concerns from patients	Concerns from staff
<ul style="list-style-type: none"> • Views not taken seriously • They'll look foolish • Won't understand issues • May cause offence • Might affect future treatment 	<ul style="list-style-type: none"> • Work will be criticised • Unrealistic demands • Undermining of role • Affect relationship • Loss of patient confidence

Table 1: Fears and concerns

Another perspective that can be used to help us understand what clinical governance is about is to use a problem solving approach. Clinical Governance can be the vehicle that takes you from your problem to your solution. This way of thinking about Clinical Governance has the advantage of showing how a lot of other areas that are involved in clinical governance fit in to the bigger picture. Underlining this is the need to consider change as at the heart of clinical governance - the notion that no change equals no difference.

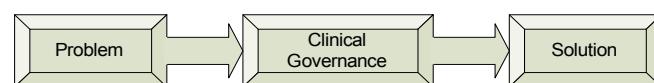


Figure 1: Change and clinical governance

The strategies employed to achieve quality and excellence, are those of teamwork, leadership, ownership and communication. All key skills to utilise when attempting to bring about changes to healthcare and more particularly in shared care services.

Teamwork: On a day-to-day basis, as we work alongside each other, we recognise the interdependence of existing working methods; there are not many of us who can provide a service alone.

Communication: Effective communication will enhance service quality and will enable, for example: effective hand-over sessions; informal one to one dialogues to learn from and with individual patients who have experienced difficult episodes of care; sensible oral and written information and clear handover mechanisms for locums; habitual, informal team reviews after clinics/surgeries; regular contact with and surveys of patients to hear their views and ideas.

Ownership: Ownership is about real participation of staff in all developments. It is about creating a working environment where structures are in place to support individuals so that professionals and teams are empowered to own, and therefore to solve, problems.

Leadership

The areas in which clinical governance is especially relevant are also the most important domains for those involved in clinical care. Patient experience, clinical effectiveness, risk management, and resource and learning effectiveness.

Clinical governance is a chance to find ways to move people out of the comfort zone of the status quo towards a more challenging culture where there is active learning, talking with 'hearing and listening' and where questions are asked in the spirit of learning and development.

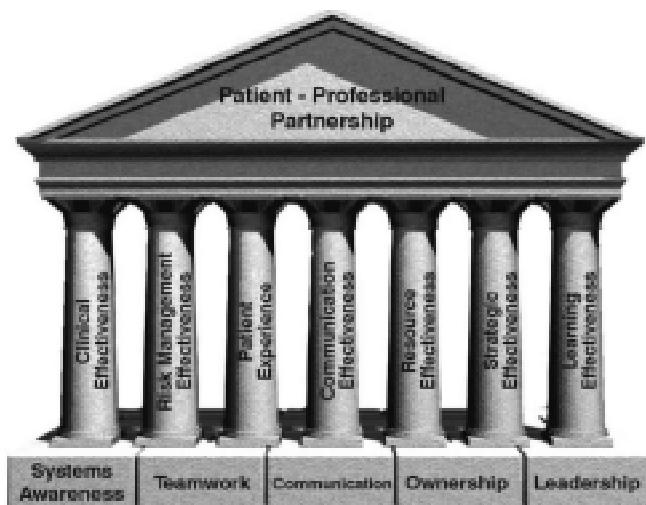


Figure 2: Pillars of clinical governance

When Clinical Governance works it can allow you to make the service changes you want to see happen, it can improve the quality of care for your patients, and it can provide a better experience for staff.

The RAID model for change stands for **R**eview, **A**gree, **I**mplement and **D**emonstrate. These four stages in the process of managing change are not discreet entities but often have a degree of overlap with one another. Some significant advantages of this model are that it may be used whatever the size and scope of the project undertaken, it is an appropriate model when dealing with a complex system such as health care and it generates ownership and involvement at every stage.



Figure 3: RAID model

The first step is to review the service or shared care process where change is needed. The review is a comprehensive information gathering process which includes listening to all staff involved with the service and to the users of the service. By doing this, staff are given ownership of the change process and will be much more likely to actively implement the changes that are recommended. Staff involved with the service are not only the people who know the service very well but also the people who will need to deliver the new service. A review will also include information from audits and relevant documentation from other sources (SMMGP, RCGP, Department of Health, NTA Reports, Shared Care Monitoring Group).

The agreement phase begins during the review when people are starting to achieve some sort of consensus as to what needs to be changed in order to build a higher quality service. Teams of those who have been involved in the review phase start to form with specific projects, identified by the review, in mind. At this stage the result of the review can often be communicated by a report which contains the specific recommendations for the service.

The implementation phase is a challenging and exciting phase. This is the stage where recommendations for change are put into practice. Project management allows specific objectives to be planned on a specific time scale with change then happening step by step, project by project. During this phase staff need help and support. Project teams also need to be able to deal with resistance to change. Problems may need to be identified, clarified and negotiated before they can be resolved.

The demonstration phase - Once projects have been completed the demonstration phase begins. This stage allows for reflective learning when performance can be assessed and lessons learnt. This stage also includes the measurement and communication of the changes that have been accomplished.

Timescales for enabling change using the RAID methodology varies but like any effective work, more time spent at the beginning (the review phase), ensuring meaningful ownership and involvement from all can often make the implementation stage occur more smoothly and more quickly.

With a problem solving approach it is easier to see where a lot of related areas fit in to the different stages of problem resolution. A more positive view of change would note that we can observe change happening around us all the time in most areas. Nothing much is immune from change of one sort or other and therefore we shouldn't feel threatened by it. Change is our chance to improve things and we can bring things that were good about the old way along, we don't want change for change's sake. We also don't always need the permission of any remote authority to enact change. With this Clinical Governance Approach the permission to make changes is often generated by the same people that are contemplating and implementing the change.

Only when we can see 'through the patients' eyes' can we be confident that we are building into organisations and systems deliverables which are really meaningful for patients at their centre (Clinical Governance: its origins and foundations, 2000)

Stephane Ibanez-de-Benito, Service Development Manager/Clinical Leader, Brent Teaching Primary Care Trust

Effective coordination of shared care

Kate Halliday reports for SMMGP on the Effective Coordination of Shared Care event on 26th April at the Manchester International Convention Centre, and the development of shared care coordinator forums to support role development and shared practice. Ed.

Over 100 people attended this half-day event in April. The afternoon was organised by a national committee of people involved in shared care coordination and was coordinated by SMMGP. The event aimed to clarify the common responsibilities and promote the importance of the role of the shared care coordinator, develop and strengthen regional shared care coordinator forums, and establish a national network of shared

care coordinators. The afternoon included both presentations and workshops. For copies of the presentations please see SMMGP website <http://www.smmgp.org.uk/html/reports/sharedcare003.php>

The day evaluated well and there were a number of action points identified including

- Focus on achieving quality at a local level, and feeding good practice to 'strategic' levels
- Develop a national qualification for shared care coordinators, based upon DANOS standards
- Develop and /or strengthen local network of people involved in coordination of shared care
- Form a national network of shared care coordinators who can develop standards, best practice and influence the national agenda
- Promote the importance of the role of shared care coordinator more widely
- Develop evidence of importance of

role, look at producing guidelines for common elements of shared care coordination e.g. commissioning, audit, shared care monitoring groups

- Treat the person and not the drug, work towards providing flexible services
- Have a yearly, day-long conference
- Plan for the future including practice based commissioning, alcohol and stimulant services in primary care, nurse and pharmacy prescribing

As a result of the day a number of new forums for shared care coordinators have been set up, and a national meeting will be held on September 28th to consider how to take the action points forward. Local shared care coordinators forums will identify people to attend this meeting. If you are interested in attending or starting a local shared care coordinators forum, please look for details on the SMMGP website <http://www.smmgp.org.uk/html/sharedcare.php> or contact

Kate Halliday, SMMGP Advisor, e-mail smmgp@btinternet.co.uk

Drug consumption rooms?

Nat Wright highlights the Joseph Rowntree report supporting the piloting of drug consumption rooms as a pragmatic response to public injecting. Ed.

On May 23rd 2006 the Joseph Rowntree foundation launched its report considering the evidence for piloting drug consumption rooms in the UK. The history is that the Home Affairs Select Committee recommended in 2002 the piloting of such centres but this recommendation was rejected at the time by Central Government. One of the principal reasons was the lack of evidence for their effectiveness.

Since that time drug consumption rooms (also referred to as supervised injecting centres or medically supervised injecting centres) have opened in Australia, Canada, Norway, Spain in addition to centres in Holland, Germany, Switzerland and Luxembourg. Arguably the centres that have been most evaluated have been those in Australia and Canada. Rigorous academic evaluation has shown some consistent and encouraging themes,

notably a reduction in heroin related deaths, a reduction in the increase in prevalence of blood borne viruses, a reduction in public injecting and needles and paraphernalia discarded in public places. The centres also served to signpost drug users into treatment. However as a harm reduction concept it would appear that it is controversial in the same way that needle exchanges were in the 1980s.

Arguments that drug consumption rooms promote or condone drug use mirror similar arguments from the 1980s when needle exchanges were first funded as a response to the rising rate of HIV infection. It has also been argued that people would not use the rooms. However, this has not been borne out by international evaluation. This has been corroborated by research conducted by the Independent Working Group showing that 42% of people attending a needle exchange had injected in a public place in the previous week. The figure was a staggering 98% for homeless drug users. Clearly those drug users who are most marginalised stand to gain most from such drug consumption rooms. The independent working group also had input from the legal profession. The legalities appear to be that legal obstacles would not be insuperable providing there was a prior agreed local accord with key agencies. This would have to include police, health and city council. Police liaison has helped in other countries to

help drug consumption rooms fulfil their purpose and not to become a magnet for dealing. It must be stressed however that the evaluations have shown that drug consumption rooms neither increase nor decrease crime (as one would expect).

Finally an argument from the public who do not work with drug users is likely to be 'why should we spend tax payers money on such facilities?' The evaluation of the Sydney drug consumption room showed that it was as cost effective as other public health interventions. European research highlighted the reduced chance of taking up a bed in hospital if a user overdosed in a drug consumption room. As the debate progresses it is possible that we have something to learn from the history regarding GPs and the morning after pill. Those who were most involved in working with marginalised groups and seeing large numbers of teenage pregnancies were most accepting of the concept of prescribing such medication. Most of us don't like public injecting anymore than we like unplanned teenage pregnancy but accepting that they are current realities, the onus is on us to consider pragmatic responses that reduce harm and improve health to both the individual and wider society.

Dr Nat Wright Clinical Director for Substance Misuse HMP Leeds



Overloaded: a quick guide to substance misuse sources

Email inbox updates, feeds, blogs, alerts, listings... approving nods or maybe no idea what this means? Worth a read either way as Anne Welsh from **DrugScope** makes the great web library a lot easier to access. Ed.

As the national drugs information charity, **DrugScope** receives an increasing number of enquiries from GPs and other primary care professionals. Many of these enquirers are looking for assistance in keeping up to date with substance misuse treatment. This brief article aims to guide you to sources that will help you do just that.

Guidelines

One of the great gifts of the online age is the ability to track down the most up-to-date editions of guidelines and regulations. However, it is important to remember that just because something is online does not mean it is recent – some websites continue to carry documents long after they have been superseded. As well as recommending SMMGP's resource library (<http://www.smmgp.org.uk/html/library.php>), we suggest people refer to the National Library for Health's Guidelines Finder (<http://www.library.nhs.uk/guidelinesfinder/>), the RCGP (<http://www.rcgp.org.uk/default.aspx?page=515>) and, of course, NICE (<http://www.nice.org.uk/page.aspx?o=cg>). The Department of Health maintains useful policy and guidelines links at <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SubstanceMisuse/fs/en> and, of course, the National Treatment Agency lists clinical guidelines on its website (<http://www.nta.nhs.uk/publications/clinical.htm>).

Core texts

New practitioners often ask us 'What are the key books I should read?' We have tried to cover these in our reading list 'Substance misuse – selected references for primary care' (<http://www.drugscope.org.uk/wip/7/PDFS/primary.pdf>), one of a series of research guides. Of particular note are Beaumont's Care of drug users in general practice: a harm reduction approach, Ghodse's Drugs and addictive behaviour and Gerada's RCGP guide to the management of substance misuse in primary care. Later this year the new edition of the BMA's Core collection of medical books and journals will be published, to which we submitted a long list of substance use texts, and which we will highlight as soon as it is available.

Current awareness

The dawn of email and RSS (Really Simple Syndication) has led to a plethora of services that you can set up to arrive in your Inbox as soon as updates are available. Confused by the technology? There's a quick guide, with links to other non-technical guides on our blog (<http://drugscope.blogspot.com/2005/09/friday-focus-feeds-for-drugdata-update.html>), and Fran Wilkie has compiled a training workbook that will take you through setting up newsfeeds step-by-step. It's available as a Word document to download from <http://www.library.nhs.uk/forlibrarians/training/materials> under the title RSS.

Sadly, the NLH's RSS Directory (<http://www.library.nhs.uk/rss/directory>) does not yet contain a specialty for substance misuse, but we assume that the Social Care, Mental Health and Occupations>Doctors sections will expand quite quickly now the directory is live.

Feeds and email listings we find useful include: Daily Dose (www.dailydose.net), a catchall of press items; Drug Misuse Information Scotland Weekly Update (www.drugmisuse.isdscotland.org); NTA Update (www.nta.nhs.uk); and SAMHSA NCADI (<http://ncadi.samhsa.gov>), covering US publications ([one of a range of SAMHSA email mailshots](http://ncadi.samhsa.gov)). Of course, we consolidate these and several more into our own blog, available to view at <http://drugscope.blogspot.com> or as a newsfeed (<http://drugscope.blogspot.com/atom.xml>), but if you want to receive information as soon as it is available, it might be worth signing up for these services yourself.

Google Alerts (<http://www.google.com/alerts?hl=en>) is a service, currently available under BETA testing, which allows you to set up 'saved searches' which are then emailed to you regularly. We are working on one for substance misuse, although it is not available publicly yet – at the moment we cannot guarantee the accuracy or authority of the items returned by the search, as we are searching the entire web for a topic that is the subject of many 'cult' sites.

As well as the blog, we do offer a range of current awareness listings – in our journal Druglink, newsletter Members' Briefing (both subscription only) and in free bulletins available from the New Books and Reports section of our website (http://www.drugscope.org.uk/library/librarysection/lib_results.asp?file=\wip\7\books.htm). Items of specific interest to GPs are usually listed under the heading 'Health Profession' and we know that several practices find checking these lists once a month a good way to look out for new publications.

In the world of print, there are several journals we recommend for current awareness. As well as Druglink and Network, those published in the UK include Drugs and Alcohol Today (<http://www.pavpub.com/pavpub/journals/DAT/index.asp>), Drink and Drug News (<http://www.drinkanddrugs.net/drinkanddrugsnews.html>) and Drug and Alcohol Findings (<http://www.drugandalcoholfindings.org.uk/>).

Of course, in a short article it is impossible to cover everything, so if you have further queries, please do not hesitate to contact us (0870 774 3682 / info@drugscope.org.uk). As information professionals, we see our role as guiding our users through the mountains of information overload.

Anne Welsh, Information Officer – Bibliographic Services, DrugScope

Heresy, dogma and the Inquisition

Supervised consumption in the real world part I

Counter-productive invasion of human rights or effective aid to treatment? In the first of two articles Nigel Modern distinguishes the articles of faith that make it heresy for some and orthodoxy for others. Ed.

I can't think of an issue which can more easily divide our treatment community. There are those who feel that to insist upon supervised consumption is an invasion of human rights and there are those who feel that to restrict its use risks bringing an effective treatment into disrepute. Supervision rates across services and even between different prescribers within services vary immensely. When I started in my current post the lack of supervised consumption caused me sleepless nights and I moved swiftly to expand the provision, yet people I have come to respect and admire opposed its introduction and argued with me persuasively, even passionately.

The international perspective – The Inquisition imported?

The British System is unique and either uniquely flawed or beneficially flexible according to your view. The intense debate in the 1990s, with rising drug-related and methadone-related deaths in the UK and many at home and abroad pointing to the relative lack of supervision here as the issue, has left a long shadow over opinion and debate. Perhaps in the context of stable UK deaths despite major expansion of services we can ask some whispered questions. Many were quite rightly concerned about the real causes of the deaths and felt that supervised consumption might be key to remedying this. Some felt the evidence was strong enough to attempt to suppress some practices they felt were wrong. Perhaps the days of the Inquisition are over, perhaps there never was an Inquisition but what I do feel is that many were concerned about how some might view the practice that they felt was sensible and safe, and one perception is that real debate about the issues suffered as a result.



Does supervised consumption prevent deaths in drug users?

Many tell us that preventing deaths is about stopping diversion of prescribed methadone and other drugs onto the illicit market and that supervision is the best way to achieve this. The main

rationale for this comes from the undisputed truth that when methadone is detected at post-mortem it is most likely that the person is not in treatment. The assumption from this that diverted methadone=increased risk of death seems to me to be a 'my glass is half empty' view ignoring the 'my glass is half full', alternative perspective. Since being in effective treatment lowers the risk of death several times it is no surprise that more commonly those who die with methadone in their tissues have bought it. Perhaps it is also right to ask if illegally bought methadone may have a beneficial effect for some but then be involved in the deaths of others. The truth is we simply do not know and perhaps we should study it further before placing too much faith in the direct suppression of drug-related deaths by reduced diversion. Perhaps there are other mechanisms for the observed effects for whenever you ask a pharmacist or other professional to supervise methadone you introduce daily contact with trained staff and all its associated benefits.

Nobody expects the Spanish Inquisition

Will watching someone take something then leaving them 24hrs unsupervised stop the risky behaviour associated with premature death? What is the evidence that it is the act of supervision bringing the benefits and not the other factors already discussed? The Inquisitors rattle their implements, I can smell the wood smoke, the stake is prepared!...someone save me for I truly believe that the evidence to separate these effects is at best scant.

Community dose assessment - A new 'orthodoxy'?

All orthodoxy was once someone's heresy.

Four new 'Articles of faith':

Article of faith number 1 - The fall in UK drug related deaths is due to a combination of many factors including more people in effective treatment and perhaps measures which lower the diversion of methadone.

Article of faith number 2 – Dose induction and then subsequent assessment, safely to adequate doses under supervised consumption and with appropriate psychosocial intervention is the best way of achieving stability of lifestyle and drug use for the majority of patients and supervised consumption can have a suppressive effect on deaths through this indirect, though highly important mechanism.

Article of faith number 3 – Patients stabilised on optimal doses using supervised consumption are less likely to divert their methadone following the cessation of supervision.

Article of faith number 4 – There can be flexibility in the use of supervision and exemption for some but this should be consistently and fairly managed. Possible criteria for exemptions would be: those who are in regular work, disability, pregnancy and women caring for their own children.

I believe many of us already operate these or similar policies but I'm not aware of where or when it has been formally recognised. In the next article I will consider what I believe to be the primary benefit of supervised consumption ie the opportunity to effectively and safely dose titrate methadone for maintenance purposes.

Dr Nigel Modern, Lead GP (Substance Misuse) Birmingham Drug Action Team and Heart of Birmingham Teaching PCT



Dr Fixit on using clinical governance to bring about change with GP under-dosing

Dear Dr Fixit

I wonder if you could help. I am a shared care coordinator for our local scheme having worked as a nurse/senior drug worker for many years. The scheme has been running for 4 years and now has 25% of local GPs involved. To be a member of the scheme you have to have completed Part 1 of the RCGP Certificate, attend CPD events and complete a yearly audit in order to claim payment.

All except one GP are fulfilling these commitments. And this is where I need your help! This GP is seeing over 20 patients for substitute medication but he has not completed Part 1 and rarely attends local training. By offering help from the scheme he has now completed his audit but we have discovered that he is largely under-dosing both with methadone (average dose 45mg) and buprenorphine (average dose 8mg). When I challenged him on this he says his patients are settled on these doses.

How can I use clinical governance structures in the PCT to challenge his practice and how do I best support this GP to improve his practice? Should I also refuse to pay him unless he completes the requirements?

Answer provided by Dr Charlie Lowe

This situation raises many questions around the practicalities of delivering the current Clinical Governance agenda. Having developed the Plymouth Primary Care Service for the last 4 years, I have reached the conclusion that this is a multi-layered, collaborative process requiring strong networking. Ultimately it should benefit both patients/clients and practitioners alike by stimulating higher

standards of care and treatment over time.

We should remember that delivering a quality service with appropriate standards is nothing new and has not suddenly been discovered by the zeitgeist that is Clinical Governance. What is new, is the performance management atmosphere seeking to demonstrate clinical accountability and value for money in our contemporary NHS. Of course GPs with their long tradition of independent contractor status, have only in recent years become exposed to the corporate environment of PCTs - with their substantial bureaucratic machinery - focused on targets and managing risk safely with the usual sticks and carrots at their disposal to stimulate change in a chosen direction.

As the question indicates there are pockets of resistance to working in the partnerships arrangements of NES or LES drug misuse schemes set up between individual GPs or their practices and a PCT or DAAT appointed lead, manager or co-ordinator. Some years ago an experienced manager once warned me that trying to get GPs to do something together was like herding cats! This may explain some of this behaviour.

The agreement with the GP is of course crucial as it sets out the expectations on both sides before the start of play. The NES is very loose in its definitions of training, practice standards, CPD and appraisal, consequently in Plymouth we went for our own LES with much more specific details and this is now on its second edition. No one gets paid until they have been trained to RCGP Certificate Course Part 1 level or equivalent. We have stipulated clear prescribing guidelines linked to a PCT-wide Substance Misuse Prescribing Policy requesting exceptions to be discussed within a multi-disciplinary team setting. All LES practices have a surgery-based drug worker who acts as an advocate at these weekly meetings attended by a GPwSI where any unusual situations can be reviewed. LES GPs receive an annual retainer of £500 p.a. for which they need to demonstrate at least 6 hours of annual CPD time. Each practice receives an annual visit from me to monitor the scheme and exchange feedback both ways picking up a few documented action points for change. An in depth comparative data report allows practices to compare themselves across a number of domains

including methadone dosages, pickup arrangements, co-prescribing of benzos and atypical longterm use of controlled drugs such as Diconal and pethidine. Within the report are briefings to update our GPs with the latest thinking and research findings in the field. We also have an over-arching Substance Misuse Governance Forum where strategic decisions around services and polices are debated and Significant Untoward Incidents are discussed and acted upon.

Returning to the problem scenario I would firstly like to say that whilst it might help having a GP managing other GPs in a Shared Care scheme, this is not essential. A local GP usually has natural links with his/her colleagues but anyone willing to get around to visit practices, get to know the individuals concerned and run the training, can also develop a sound communication system. There will be occasions when communication is not working as well as hoped for and such concerns should be shared with other colleagues to explore ways around the difficulty. PCTs are regularly sending small teams to visit practices under the Quality Outcome Framework (QOF) or initiatives from Prescribing Teams often with Pharmacy input. Others will be able to advise or offer themselves as a link such as another local GP or GPwSI. The important point is to set up dialogue and to avoid outright conflicts - unless the circumstances are very serious and there is no other choice.

I have noticed in my work that GPs don't like to be the outliers on a graph and so sharing comparative data with them in a non-judgemental fashion can bring about significant changes to practice. The methadone dose issue is explored by Strang et al who found a mean dose of 37ml/day in their survey of GPs in England and Wales. This was published in the June edition of the BJGP and sending a copy would create an opening to further talks. We must not assume that this GP is ignorant but we do need to check that his decision-making is soundly based. He can justify his/her doses if the patients' outcome measures are positive such as having a good working relationship with the GP, attending appointments or day services, satisfactory drug screening results, low use on top, training, activity and delivering on care plan goals. Without this sort of evidence then we don't really know what is going on and it is the GP's responsibility (jointly with a drug

worker if there is one) to demonstrate good standards of care on demand from the scheme co-ordinator.

Sometimes a financial twist of the arm can help such as withholding payments until certain actions have occurred e.g. attending accredited training. Of course the co-ordinator must apologize profusely blaming the bureaucrats upstairs so that the ongoing working relationship is preserved. No practitioner is an island if you see what I mean. This is particularly pertinent to the field of addiction where a transparent and open working environment is a safer one for all concerned since both drugs and alcohol love to be sly.

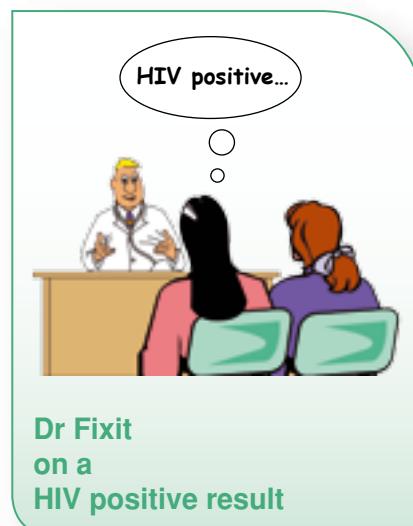
At the end of the day if the co-ordinator is not happy with working arrangements despite best attempts to rectify matters, then they are liberty to terminate the agreement with the GP as they act on behalf of the PCT or DAAT who fund these schemes who will expect as much. Terminations should be the action of last resort, as this will certainly create difficulties for patients in receipt of treatment for whom contingency plans may be needed.

I have infact stopped one GP operating under our LES scheme since despite his training, his idiosyncratic interpretation of prescribing gave several of us cause for concern. It was achieved very agreeably when I persuaded him to let me take over his small number of patients while he continued with their general medical care. Analysis of PACT prescribing data each quarter for methadone and buprenorphine across all practices allows us to monitor the situation.

Written correspondence is obligatory to confirm how the two parties have proceeded and please don't forget the Local Medical Committee (LMC). They need early warning of a potential conflict so that they have scope to negotiate and for those who don't know this, I would commend their skills and experience in unravelling complicated GP situations in their role as GP representatives through the BMA.

Dr Charlie Lowe

Plymouth PCT Primary Care Lead & GP Specialist in Substance Misuse



**Following from last issue,
Dr Ewen Stewart continues with
his second consultation with
Chiara**

Thanks for your help with screening Chiara for blood born viruses. You will remember she is Italian, had recently registered and had come to live with her boyfriend in London. She is stabilised on 90mg of methadone daily. She had requested a HIV test as she is worried as one of her using friends has just been diagnosed in Italy. She speaks excellent English but had little understanding of HIV and other viruses that she may be at risk of, such as hepatitis B and C.

I now have her HIV test back and it is positive. She is coming into see me tomorrow – how do I tell her this result?

Answer provided by Dr Ewen Stewart

Although Chiara may be expecting this result she is still likely to be worried and will be upset when she gets the result. It is important that she is told in person, not over the telephone, and we hope that she has taken your advice to bring someone with her when she gets the result. It is better to tell her that she has a positive result early in the consultation rather than talking around it beforehand. Rehearse wording that you might use – it should be clear and concise. 'Chiara I have the result of your HIV test and it has come back positive which means that you are infected with HIV'. Allow her time for this register and give opportunities for her to ask questions throughout this consultation.

You will need to reiterate some of the

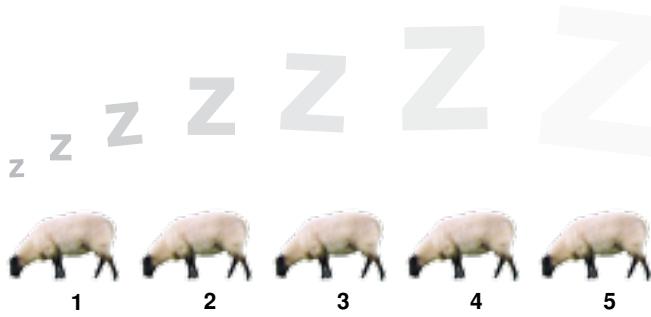
information that you covered in the pre-test discussion as this news can make it hard to remember important facts. You should tell her that it does not mean that she AIDS, that you cannot tell from this result how long she has been infected and nor how the virus has affected her immune system.

Emphasise that she will need referral to a specialist for further assessment and that good treatments are available to control the infection if she needs them. I find it useful to tell patients that we expect most people with HIV to have a normal life-expectancy with current treatments. You may want to check a CD4 blood count at this stage but this should not delay referral. The CD4 count is used to determine the level of damage done to the person's immune system and to help decide when to start anti-HIV treatment. It is useful in general practice because it can be used to judge whether a presenting condition, such as chest infection, is likely to be related to their HIV disease. In general a patient who has a CD4 count of below 200 is more likely to have an opportunistic infection requiring specialist attention.

Ask her what is the worst thing about this news? This will allow you to address her main fears and worries – which can range from fear of death and dying to having to tell her family. Offer her support and give her telephone numbers for agencies such as the National Sexual Health Helpline (0800 567 123). Who does she have to tell? And who does she not have to tell? Most employers do not need to know unless she is carrying out exposure prone procedures.

You should aim to address issues of prevention and harm reduction although this may not be possible in this first consultation. Issues such as safer sex and safer injecting need to be raised. Establishing whether she has a current partner, how she will tell them and negotiating safer sex, all need to be considered.

Arrange to see her again and set up an urgent appointment at your local HIV clinic. Ask her what she will do over the next few days and where she will get support if she needs it. Offer support from the practice and arrange to see her while she is awaiting her hospital appointment. Patients with HIV can disappear into the hospital system and building up a good relationship at this stage can help to maintain their contact with primary care.



Sleep management and methadone

Kim Wolff addresses how to get a good night's sleep whilst on methadone, a topic that many seem unsure about. Ed.

It is important to identify any underlying problem

Getting a good night's sleep is an important factor in keeping fit and healthy. It has been reported that 10-15% substance misusers have chronic sleep problems (Kupfer & Reynolds, 1997), insomnia being likely to be worse in those with co-dependence on different substances such as cocaine and heroin (Lucas et al, 1996). Difficulty with sleep may also be related to overlapping problems such as anxiety and depression, which are well known to increase sleep disturbance.

1. It is important to ensure that the methadone dose is adequate

Sleep disturbance (unable to get to sleep, remain asleep) is a well known symptom of opiate withdrawal (Stein et al, 2004): The degree of sleep difficulty being increased in the early phases of (acute withdrawal) of heroin withdrawal.

Hence, problems with sleep are a common feature of opioid detoxification programmes. Withdrawing from benzodiazepine and opioid drugs together enhance noradrenaline release and exacerbate withdrawal, which may enhance sleep disturbance

(de Wet, 2005).

Management of sleep may also emerge as a problem during methadone reduction (Kay 1994; Lukas et al, 1996) and monitoring opioid withdrawal symptoms is recommended. The severity of methadone withdrawal symptoms have been shown to be a consistent predictor of sleep (total sleep) time (Beswick et al, 2003).

2. Self medication of methadone to improve sleep is not recommended

It has been shown that clients on Methadone Maintenance Treatment programmes often have difficulty in initiating and maintaining sleep. Both inadequate quality and quantity of sleep have been reported (Oyefeso et al, 1997). Splitting the methadone dose in order to enhance sleep particularly if experiencing withdrawal symptoms has become commonplace for some.

Dosing with methadone at bed time is associated with risk of overdose particularly if taken in combination with other CNS depressant substances (benzodiazepines, alcohol). Methadone is a slow acting, long acting drug that depresses the CNS even in tolerant individuals, and with sleep which augments CNS depression creates a cumulative effect. Often in such circumstances the respiratory rate appears normal whilst blood gas analysis show hypoxia and hypercarbia. Methadone also reduces or eliminates the normal drive to re-commence respiration or increase the respiratory rate if diminished thus if asleep the individual may not recover.

An optimal dose of methadone consumed late morning should be more than adequate protection from opioid withdrawal symptom complaints. It is better to take the first dose of the day a little later than split the dose and consume methadone at night and risk intoxication.

Kim Wolff Senior Lecturer in the Addictions, Head of Taught Graduate Studies, Kings College London

Models of Care for Alcohol Misusers (MOCAM) at last!



After over almost a year in draft format the long awaited alcohol commissioning guidance Models of Care for Alcohol Misusers (MOCAM) has been published on the DH Website <http://www.dh.gov.uk/assetRoot/04/13/68/09/04136809.pdf>

In common with Models for Care for Drugs it recommends commissioning all treatment tiers as part of a whole treatment system. The guidelines place a firm emphasis on a significant role for primary care and in particular screening and brief interventions. However, it is already clear that many PCTs and DATs are going to struggle to identify resources to support alcohol treatment services in the current NHS financial climate.

Practice based commissioning and local enhanced services provide obvious routes to funding new primary care and shared care alcohol provision and the RCGP SMU and Alcohol Concern are soon to publish a briefing paper to assist practitioners lobby for funds through this route. In addition there are opportunities to resource primary care by forging partnerships with probation and primary care mental health services both of whom are seeking ways of addressing the links between alcohol related violent crime and antisocial behaviour and chronic anxiety and depression.

The RCGP SMU has an alcohol training package to support the development of alcohol screening and brief interventions. The training is compliant with MOCAM and can be adapted to support the specific needs of localities. The training is designed to be multidisciplinary and could accommodate practitioners from other agencies. For more information please contact Jo Betterton RCGP Substance Misuse Unit, Suite 314, Frazer House, 32-38 Leman Street, London, E1 8EW, 0207 1736093. www.rcgp.org.uk/substancemisuse

Dr Linda Harris, Director RCGP SMU

BULLETIN BOARD

Drug & Alcohol Professionals Conference, 8 November 2006. Royal Institute of British Architects, London W1B 1AD. The Federation of Drug and Alcohol Professionals (FDAP) annual conference, held in association with Drink & Drugs News, aims to help support the development of front line workers, managers and commissioners, and to give delegates the opportunity to have their say on important issues of the day. Plenary presentations on the future of alcohol services, residential rehab, harm reduction and workforce development. Workshops include: steroid users; young people; co-occurring gambling problems; brief therapies for alcohol problems; and, managing child protection issues. Information and a booking at www.fdap.org.uk, 0870 763 6139.

3rd National Conference on Sexual Health & Contraception in General Practice on 17th November 2006, Sex in the Surgery: Making it Happen in Practice. UK sexual health is still among the poorest in Europe. How can we, working in general practice, improve our practice in sexual health? Themes include: developing practice e.g. managing HIV in primary care; STI testing in general practice; the future of medical education for general practice on sexual health; developing local leadership and networks; and care pathways centred on service users. Contact Heather Malcolm on 020 7604 4826/SHOC@gp-E84025.nhs.uk

2nd National Conference on Drug-Related Deaths - 15th November 2006. The Lowry Hotel, Manchester. Reducing drug-related deaths (DRDs) remains a key issue for all services. This one day conference will explore the causes, impacts and ways to reduce tenance, the role of prisons in reducing DRDs. Contact Salman Desai, Greater Manchester Ambulance Service NHS Trust. Tel: 01204 492419 Fax: 01204 497029 info@gmas.nhs.uk

Advancing Harm Reduction - International Lessons for Local Practice, 7th September 2006, London, WC1E 7HT. A one-day conference organised as an opportunity to update on the key themes of the Vancouver International Harm Reduction Conference: advances in the development of user advocacy; work on tackling bacterial and viral infections; engaging young people in harm reduction; developments in harm reduction and heroin use; evidence from heroin trials; conference 'fringe' meetings report; new UK developments including the Joseph Rowntree report on consumption rooms and a recent study on non-problematic heroin use. For further details and registration forms, please contact Michelle Vatin at the Conference Consortium, Tel/fax 0207 2726902 conference.consortium@rugbyhouse.org.uk

'Knowing the Score: Learning from the Positive Futures case study research project' 7th and 8th November 2006 Sheffield United Football Club. A conference about engaging young people at risk of involvement in drug use and criminal behaviour in constructive activities within the community, particularly the use of sport and other arts and cultural activities. The conference will also see the launch of an independent study of the scheme, co-ordinated by Sheffield Hallam University. Organised by the Conference Consortium. Contact: Michelle Vatin conference.consortium@rugbyhouse.org.uk

'Alcohol, Drugs and Criminal Justice - building on experience and looking towards 2008' 26th to 28th March 2007, the University of Warwick. Second national conference for those working within the overlapping fields of offending, drugs and alcohol. The programme will be a mixture of plenary sessions, panel discussions and debates and workshops, which will examine developments in good practice and look forward to the opportunities presented by the national alcohol strategy and the new national drug strategy in 2008. Organised by the Conference Consortium, contact Michelle Vatin conference.consortium@rugbyhouse.org.uk

RCPG Part 1 Certificate in the Management of Substance Misuse face-to-face training.

National face-to-face training dates: 13 September, October, Bromley; 1 November, Lancashire (location TBC); 10 November, Gateshead. More details at www.rcgp.org.uk/substance misuse or contact Tom Inkelaar, Part 1 Co-ordinator, RCGP Substance Misuse Unit, 0207 173 6093 TInkelaar@rcgp.org.uk

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